STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013356	A. BUILDING: _____ B. WING _____	10/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS ASSISTED LIVING	7133 MEADOW TRAIL BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for an Initial State Residential Licensure Survey. Survey date: October 20 & 21, 2014 Facility number: 013356 Provider Number: N/A Aim Number: N/A Survey team: Megan Burgess, RN, TC Lora Brettnacher, RN (10/21/14) Tracina Moody, RN Census bed type: Residential: 29 Total: 29 Census by payor type: Other: 29 Total: 29 Sample: 7 Brownsburg Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Initial State Residential Licensure Survey. Quality Review 10/21/14 by Lisa McColly	R 000		